Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
5501 SOUTH MCCOLL RD
EDINBURG TX 78539-9152

Respondent Name
LA JOYA ISD

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-12-3002-01

MFDR Date Received
May 29, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Labor Code 134.403"

Amount in Dispute: $2,001.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The total reimbursement with the 200% markup is $999.56. Therefore, no additional allowance is due."

Response Submitted by: Argus, 811 S. Central Expressway, Suite 440, Richardson, Texas 75080

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 16, 2012	Outpatient Hospital Services	$2,001.72	$854.87

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 219A – Based on extent of injury.*Supplies/Services are not (or appear not to be) related to the compensable injury.*

- W1TA – Workers Compensation State Fee Schedule Adjustment. *Medicare outpatient hospital specific reimbursement amount multiplied by 200%. DWC rule 134.403.*
- 97H – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. *Service(s) / Procedure is included in the value of another service/procedure billed on the same date.*
- W3A – Additional payment made on appeal/reconsideration. *Thank-you for your inquiry. Upon re-review, additional benefit is recommended.*
- 193Z – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. *Thank-you for your inquiry. No additional reimbursement allowed after review of appeal/reconsideration.*

Issues

1. Are there unresolved issues of extent or compensability of the injury?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code 219A – "Based on extent of injury. *Supplies/ Services are not (or appear not to be) related to the compensable injury.*" Review of the insurance carrier's response to the provider's request for reconsideration finds that the insurance carrier did not maintain this denial upon appeal. Further review finds that the insurance carrier did not file a form PLN-11 with the Division, nor does the respondent raise any issues of extent or compensability in their position statement filed in response to this dispute. The Division therefore concludes that there are no unresolved issues of extent or liability for the compensable injury. This denial code is not supported; therefore, the disputed services will be reviewed per applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 82565 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $7.22. 125% of this amount is $9.03. The recommended payment is $9.03.

   - Procedure codes 72157 and 72158 have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated MRI procedures

performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. These services are assigned to composite APC 8008, for MRI services including administration of a contrast agent. This composite APC has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. Per OPPS Addendum A, APC 8008 has a payment rate of $1,000.68. This amount multiplied by 60% yields an unadjusted labor-related amount of $600.41. This amount multiplied by the annual wage index for this facility of 0.8824 yields an adjusted labor-related amount of $529.80. The non-labor related portion is 40% of the APC rate or $400.27. The sum of the labor and non-labor related amounts is $930.07. The service cost for this line item of $1,163.42 added to the allocated portion of all packaged costs of $162.36 yields a total cost for this composite line item of $1,325.78. The cost of this service does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total APC payment for this service is $930.07. This amount multiplied by 200% yields a MAR of $1,860.14.

- Procedure code A9579 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

5. The total allowable reimbursement for the services in dispute is $1,869.17. This amount less the amount previously paid by the insurance carrier of $1,014.30 leaves an amount due to the requestor of $854.87. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $854.87.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $854.87, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 6, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.